The benefits of spacer devices over nebulisers in acute childhood asthma may not be as earth shattering as whether the sun or the earth is the centre of the solar system but it addresses an important issue in one of the commonest childhood disorders of our time.

How many of us can honestly say that spacer devices have mainly taken the place of nebulisers in our emergency rooms and in our paediatric wards?

For this reason I think the paper by Powell and his colleagues is immensely important. It shows, in an exemplary way, what managerial steps need to be taken to adopt scientifically proven research results. For true consensus to occur much explanation and discussion is needed. Didactic decisions will inevitably result in failure because colleagues and their views have not been treated with respect.

The paper by Bero and colleagues[1] is also well worth reading for anyone wishing to undertake similar changes. We may be told that we are living in a world of ever increasing and rapid change, but in reality few of these changes we readily accept at face value and if we are not careful, conflict ensues.

In the paediatric respiratory world perhaps I could ask all readers of *ADC*: (1) Do you use once daily intravenous gentamicin or still believe three times daily is better? (2) Do you try to restrict trainee doctors obtaining chest *x* rays in acute asthma? (3) Do you still use beta agonists, inhaled corticosteroids, or ipratropium bromide in acute viral bronchiolitis? (4) Do you have strict criteria for the use of antibiotics in chest infections, the majority of which are viral in origin? (The decision to institute antibiotic therapy can often be delayed until a subsequent consultant ward round, provided that clear protocols are in place) (5) Do you allow patients under the age of 8 years to use breath actuated devices when it has been shown they are unlikely to inhale significant amounts into their lungs?

I suspect we all have a long way to go in optimising delivery of care as shown by well constructed and well executed research studies. We can do far worse than to follow the recommendations of Powell and colleagues.

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1 Bero LA, Grilli R, Grimshaw JM, *et al*. Closing the gap between research and practice: an overview of systemic reviews and interventions to promote the implementation of research findings. *BMJ* 1998;**317**:465–8.

End of the line for cromoglycate?

Inhaled disodium cromoglycate has been used as maintenance treatment for asthma for over 30 years and is recommended in current guidelines. Nevertheless, in clinical practice over the last 10 years it has been largely replaced by inhaled steroids. Now a systematic review by workers in the Netherlands (MJA Tasche and colleagues. *Thorax* 2000;**55**:913–20) may be the coup de grâce.

The review included 24 randomised controlled trials of disodium cromoglycate in children. Overall, methodology was assessed as weak, especially as regards treatment compliance, selection and inclusion, and statistics and analysis. Funnel plots indicated publication bias with missing small, negative studies. Treatment effects on wheeze and cough were small and tolerance intervals for both included zero. The more recent studies showed results less favourable to disodium cromoglycate. The authors conclude that disodium cromoglycate has not been proved to be better than placebo in the maintenance treatment of childhood asthma and that its promotion as a first line prophylactic treatment is no longer justified.

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